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ABSTRACT

The objective of this analysis is to outline in broad fashion the current trends and issues in the licensure of health manpower and to contrast two proposed alternative systems of credentialing that focus on licensure of health care institutions instead of individual health care providers. The argument of the analysis is that the current system of individual licensure both falls short in its primary purpose of assuring the quality of health care and results in a number of legal problems for health care practitioners that adversely affect the delivery of health care in the United States today. Two recent proposals (The Carlson proposal and the Hershey proposal) for change in the system for individual licensure are contrasted with respect to their potential for resolving the major problems of the current system and their possible impact on the health care delivery system. Recent trends in court decisions involving claims of malpractice and issues of responsibility and liability for the equality of health care are also used as a basis for analysis of the two proposals. (Author)

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HEALTH MANPOWER CREDENTIALING: LEGAL IMPLICATIONS OF INSTITUTIONAL LICENSURE

by Stephen Crane

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SUMMARY

The objective of this analysis is to outline in broad fashion the current trends and issues in the licensure of health manpower and to contrast two proposed alternative systems of credentialing which focus on licensure of health care institutions instead of individual health care providers. The argument of the analysis is that the current system of individual licensure both falls short in its primary purpose of assuring the quality of the health care provided and results in a number of legal problems for health care practitioners which adversely affect the delivery of health care in the United States today.

Two recent proposals for change in the system of individual licensure are contrasted with respect to their potential for resolving the major legal problems of the current system and their possible impact on the health care delivery system. Recent trends in court decisions involving claims of malpractice and issues of responsibility and liability for the quality of health care are also used as a basis for analysis of the two proposals.

The analysis concludes that while both proposals offer solutions for the significant legal problems resulting from restrictive definitions of scopes of practice under the existing system of individual licensure (the Carlson proposal to a much greater degree than the Hershey proposal), only the Carlson proposal, which emphasizes performance monitoring, equipment as well as personnel review, and development of a medical injury liability compensation system, offers real promise of achieving the objective of the control of the quality of health care and hence the protection of the public's health and safety. The technology and means necessary to implement this proposal, however, are yet poorly developed.

I. Background and Bases for Licensure in the Health Field

The tenth amendment to the Federal Constitution states that "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or the people." One important authority reserved to the states are the so-called "police powers" which are defined as the right of a state to impose restrictions on individual liberty and use of property in order to protect the health, safety and well being of the public. The exercise of this power, of course, is limited by the fourteenth amendment provisions for due process and equal protection, as well as by other legislative pronouncements of national intent and purpose such as the Civil Rights Act of 1964.

State licensure of individuals within specified occupations and professions is one form of the exercise of such state police power. Licensure may be defined in broad terms as:

> The process by which an agency of government grants permission to persons to engage in a given profession or occupation by certifying that those licensed have attained the minimal degree of competency necessary to ensure that the public health, safety, and welfare will be reasonably well protected.[1]

Licensure as a process is distinguished from other forms of credentialing by the nature of the licensing agency, i.e. a branch of government, and the conferring of a legal right on one group of individuals above all other individuals to practice in a profession or occupation or to use a specific title. In recent years, particularly in health professions credentialing, the processes of accreditation, certification and

registration have become interwoven with that of licensure. Accreditation as distinguished from licensure is:

> The process by which an agency or organization evaluates and recognizes an institution or program of study as meeting certain pre-determined criteria or standards.[2]

Certification or registration is:

> The process by which a non-governmental agency or association grants recognition to an individual who has met certain pre-determined qualifications specified by that agency or association. Such qualifications may include: (a) graduation from an accredited or approved program; (b) acceptable performance on a qualifying examination or a series of examinations; and/or (c) completion of a given amount of work experience.[3]

The overlap among these processes occurs principally when the requirements of one process, for instance certification, are used as qualifications within another process, such as licensure. While each process is important for an overall understanding of health manpower credentialing, this analysis will focus specifically on the process of licensure and will consider these other processes only insofar as they impact on the process of licensure.

State licensure emerged as an important factor within the health care field after the Supreme Court removed the laissez-faire doctrine of freedom of contract from the area of health in the late nineteenth and early twentieth centuries.[4] Through the medical practice acts which were adopted by all of the states after that time, physicians were granted an unlimited scope of practice, while all other individuals were prohibited from "diagnosing" or "prescribing treatment" for medical problems except within carefully defined areas. Professions such as dentistry and nursing were quick to draft practice acts of their own both to increase the quality of care provided by their profession and to protect their

profession from competing interests.

The principal argument used in support of such legislation was the need to protect the public's health and safety from unscrupulous and poorly trained practitioners. Licensure laws embedded within medical practice acts established minimum standards for entry into a profession and regulated those who could call themselves a physician or a dentist, etc. Medical practice acts assured "universal applications of definitions of practice, thus providing a uniform basis for resolving problems of scope of practice and delegation."[5] Theoretically, therefore, licensure and medical practice acts were used to assure a certain minimum level of quality of health care professional.

II. Public Interest Theory Challenged

A number of scholars recently have raised issue with the public interest theory of professional licensure, in essence arguing that licensure statutes are enacted more for the self-interest of the profession than for the protection of the public's interest. Moore, Stigler and Frech have particularly struck hard on this theme in several articles.[6]

Moore and Stigler, both using the year of licensure as an initial measure of the strength of the licensure movement in various professions, argue that licensure has served the private pecuniary interests of the professions more than the public's interest in quality control. Stigler correlated the year of initial licensure of a profession with the per capita incomes of members of that profession to show the relative private gain accruing to the profession as a result of licensure, when compared to income trends in other unlicensed professions.[7] Moore found that

earliness of licensure was significantly related to the higher educational level and higher total income of these professions as compared with other professions. Moore suggested that these facts were consistent with the notion that licensure serves not only as protection of the public from untrained practitioners, but also as an important means by which licensed professions increase their private return.[8] Frech in his paper argued that such phenomena as entry standards for professions, prohibitions on substitution of personnel and competition, and a highly structured professional organization were used by professions more to serve their own private interests than to provide adequate quality control for the public.[9] An example cited by Frech in support of this contention is the specification by most medical professions of highly restrictive scopes of practice which prohibit competent, but non-member practitioners, from performing certain acts. Where manpower is in short supply, such a prohibition increases the price which a professional member may charge for his services as well as denying care to some who may not be able to meet the price or gain access to the limited supply of care. In this sense, the public is hurt not helped by licensure statutes.

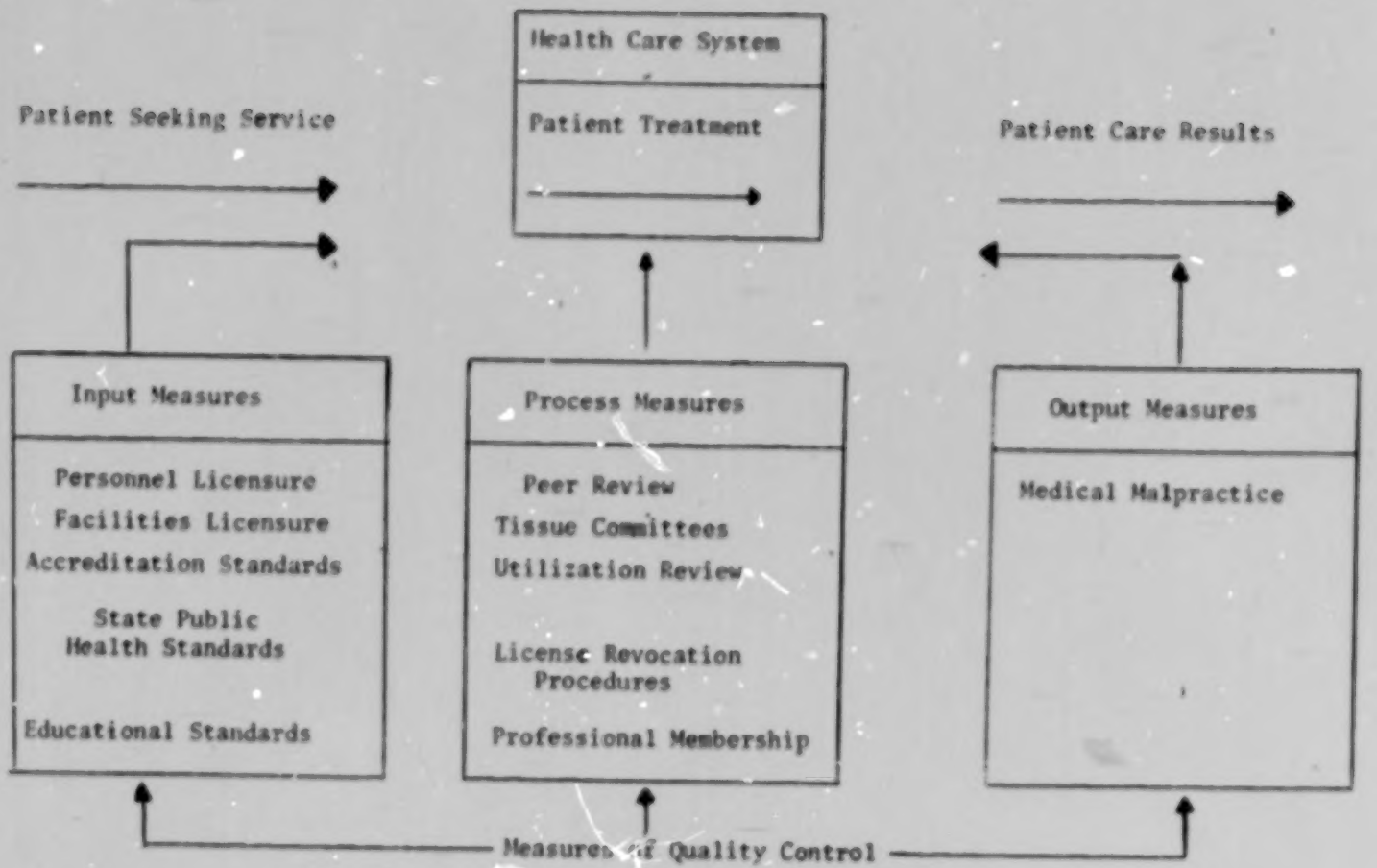
The issue raised by each of these studies is the question of the appropriate role for professional organizations, representing private interests, in the protection of what is most fundamentally the public's interest-its health and safety. Since the 1850's when states took over the regulation and licensing of medical practitioners from professional societies in order to improve the deteriorating quality of care, the role of the professional organization has come full circle to a point

now where the professions have again asserted their control over medical care.[10] Two important trends reinforcing the rise of professional societies to position of dominance have been the move from voluntary to compulsory licensure and the increased participation by representatives of the medical profession on state licensing boards.[11]

Whether the existing system of licensure in fact can operate to control quality at all represents another dimension of the challenge to the public interest theory of licensure current today. Richard Carlson presents an excellent analysis of the failings of the individual licensure system to assure quality health care in his critique of the current health manpower credentialing system.[12] Carlson suggests that three sets of mechanisms exist for potential control of the quality of care: input, process, and output measures.[13]

The ideal regulatory system to assure control of quality would concentrate on measures and standards of outcome, rather than input or process measures, as it is the ultimate result of an action that is most relevant for the patient's safety and health. Because our ability to measure and assess such outcomes is yet very weak, establishment of such outcome standards must be left to the process of litigation which is at best problematical. Alternatively as the diagram illustrates, input and process measures are used as the next best method for controlling quality. The problem with all of these measures, however, particularly with individual licensure, is that there is no necessary relationship between the factors measured and the ultimate outcome. An individual seeking to be licensed as a Registered Nurse may have all of the requisite educational and training qualifications and yet still be unable to perform

Health Care System Quality Controls



(Rick J. Carlson, "Health Manpower Licensing and Emerging Institutional Responsibility for the Quality of Care," Law and Contemporary Problems, Vol.35, No.4 (Autumn 1970), p.862).

properly many of the procedures which she will be called upon to do. The current system of individual licensure furthermore provides little check on the continuing quality and competence of a practitioner over time. Licensure tends to be a one time event with only nominal requirements for relicensure. Finally, the desire of most professional boards to police their own professions is minimal, suggesting that many persons who should perhaps be barred from practice on the basis of qualifications or competence are allowed to continue to practice virtually unchecked.

Aside from the specific question of the measurement of quality and the issue of private vs. public benefit, the real import of the current system of health manpower credentialing may best be measured in terms of the impact which this system has on the delivery of health care.

III. Significance of the System for Individual Licensure for Health Care Delivery

In referring to the development of the system of individual licensure as it relates to the delivery of health care, Carlson states:

> ...As licensure laws have evolved, the licensure system has grown cumbersome and outmoded. Its historic course resembles an ecological remedy designed to cure a specific problem only to become one-a-species of rodent imported to curb the rapacious behavior of another pest only to succeed to the extent of setting off another imbalance. Licensure would likely fall of its own weight except for a reverence for professionalism which proves a paraphrase of Veblen's maxim: nothing defends itself more vigorously than a health care profession threatened with the loss of its licensure statute.[14]

The analogy between the effect of individual licensure and a problem of ecologic balance is particularly apt given the multiple effects which this system has on the delivery of health care. To cite just several of the more important problems, the specification of narrowly defined scopes

of practice as part of the individual professional licensure system has led to a fragmentation of the health care treatment process where many individuals, each with specially licensed skills, are needed to do tasks formerly done by one or two people. This fragmentation and proliferation of specialized occupations has diminished continuity in the delivery of health care by diffusing the responsibility for care of the patient among more individuals. At the same time the proliferation of occupations and the restrictions placed on the practices of these individuals have prevented more rational organization and utilization of existing personnel.

The education and general training requirement of licensure have erected significant barriers to the entry of more individuals into the health care system, particularly those from less affluent backgrounds. This restriction on the supply of health manpower has meant that less health care is available today than might otherwise have been available. The rigid standards and requirements for entry into professions have also prohibited greater vertical and horizontal career mobility. In many cases, the inability to move up in a profession or to shift to a different profession has lead to considerable dissatisfaction among health care workers and high job turnover rates which exacerbate the problem of supply. The wide variations in licensure requirements among states for the same profession have inhibited geographic or horizontal mobility which decreases the availability and accessibility of care for large portions of the population. Finally, licensure has failed to assure a minimum level of quality because of the problems noted earlier, while significantly adding to the cost of care through supply restrictions and restrictions on

more efficient and effective utilization of personnel.

The list could continue, but the point concerning the centrality and significance of the system for individual licensure for health care delivery has probably been well illustrated. Several trends reinforce the urgency of the need for change in our current system of health manpower licensure. First, the rapid increase in our knowledge of disease processes and health care, the increasing complexity of the technology used to deal with these problems, and the proliferation of the number of licensed specialty fields promise to aggravate and further compound the already serious problems of fragmentation within the current system of health care delivery. Secondly, the delivery of the care is rapidly becoming institutionally based whether through a hospital, an ambulatory care center, or a group practice clinic. This trend raises both the need for and the threat of more "process" controls, in Carlson's terminology, while at the same time offering a greater opportunity for better measurement of "outcome" and performance through the use of computer technology and data analyses.[15] Thirdly, the rapidly increasing demand for health care, coupled with a relatively inelastic supply of health care professionals, partly as a result of the licensure system, has led directly to the development of new types of intermediate medical personnel who not only assist the physician, but who can also substitute for the physician as well.[16] The legal right to employ such persons and the ability to utilize these individuals most effectively, however, is severely constrained by scope of practice provisions in licensure and medical practice acts which make delegation of medical tasks to those individuals very hazardous legally. The greatest pressure for change in the current system of indivi-

dual licensure, therefore, derives from the need to increase the use of such intermediate personnel to meet the growing demand for quality health care for all.

IV. Proposed Alternatives to Individual Licensure

Changes have been proposed for the system of individual licensure along three different lines. The first proposed direction of change is towards a system of national credentialing and licensure of health manpower which would maintain existing categories of personnel but do away with individual state licensure. Such a national system would improve the mobility of personnel among states by removing the many differing requirements for state licensure, but would not directly affect the problem of the proliferation of new categories of personnel. Depending of course on how narrowly the scopes of practice for each profession would be drawn in federal legislation, this proposal, for a national system of licensure would not significantly improve the possibilities for utilizing personnel more effectively.

A second major direction of change relates to attempts to minimize the influence which professional organizations have over state licensure mechanisms while preserving the basic integrity of the state licensure system. Harris Cohen identifies three specific proposals along these lines.[17] First is the move towards "public licensure" which would expand consumer and state representation on existing licensure boards. Success of this strategy, however, would depend on the status and autonomy given to these public members, the extent of participation and authority to challenge decisions made by the professionals allowed the public members, and the availability of a constituency to support the position taken by these public members.

A second proposal involving de-emphasis of professional control is for "reorganization of licensing boards." All licensing boards, in effect, would be consolidated into a single board with professions either sending one delegate to a plenary-type board or providing an advisory subcommittee to make recommendations concerning its profession to the whole board. The one delegate, one vote system may not provide sufficient input to assure reasoned and informed decisions about a profession, while an advisory committee system may prove no different from the existing system of individual boards, depending again on the amount of challenge and autonomy allowed the full board in its ultimate decision concerning a profession.

A third proposal is for a system of "joint regulation." Under the proposal, all existing licensing boards would sit in review of all new applications for licenses for new professions and would decide as well on the definition and requirement for licensure and practice in that profession. The idea behind this proposal is to force greater coordination among the already existing boards with a minimum of disruption or change in the system. The major problems with this type of suggestion, however, are that it simply extends the current system of licensure without major change, it maintains all existing licensed professions providing no guarantee of greater coordination of tasks among professions nor of a decrease in the fragmentation of health occupations, and it does not assure any greater responsiveness to consumer needs than existing boards.

The final major direction for change in licensure of health manpower is for "institutional licensure." Except for independent practitioners, licenses would no longer be granted to individuals per se. Under

institutional licensure, the health care institution would assume full responsibility for the certification of its personnel and their use. The proposal for institutional licensure represents the broadest type of reform in the licensure system currently being considered at the state and national level. The remainder of this analysis will focus on two specific proposals for institutional licensure and will attempt to describe briefly a number of the legal implications of each as well as the prospects for change in the delivery of health care to result from both proposals.

V. Two Proposals for Institutional Licensure

Nathan Hershey was the first to propose the concept of institutional licensure.[18] The two key elements in Hershey's proposal are the elimination of all licensure statutes except for "independent practitioners" and the establishment of a single comprehensive system for licensure of institutions at the state level. Licensed institutions under the proposal would employ "dependent practitioners" based on the skills of the individual and job descriptions for their work approved by the state agency regulating facilities. Independent practitioners are defined as physicians, dentists, optometrists and podiatrists while all other practitioners, including RN's, are considered to be dependent practitioners. Licensure is maintained for independent practioners based on the rationale that such individuals work independently of all others and therefore must have control over the determination of their activities to fulfill their legal responsibilities to the patient. The qualifications and background of these independent providers may be far more relevant to their ultimate output or service than for dependent practitioners who technically

work only at the direction of an independent practitioner (RN's would take extreme exception to this formulation, of course, and have).

The innovative aspect of Hershey's proposal is the plan to license institutions instead of individuals. To obtain a license, each health care institution, including a physician's private office, would submit a list of job descriptions to a state regulatory agency describing the qualifications of persons sought and the duties to which they would be assigned. The institution would be licensed on the basis of how it planned to use these people and successful presentation of proof of compliance with the standards which the institutions have established for themselves. The point in giving such discretion to health care institutions is to provide greater flexibility to the institution for defining the ways in which available manpower can best be utilized. Legally, the current restrictive limitations of licensure statutes and professional practice acts must be removed to permit such new delegations. A person's legal authority to perform a specified act under the Hershey proposal would be related to the skills which he possesses and the functional requirements of the tasks to be assigned, rather than to the broad qualifications of a general field or occupation which may have little applicability to the job to be done.

Carlson uses the same arguments as Hershey to support his proposal for institutional licensure, but formulates a slightly different plan based on four essential elements: (1) repeal of licensure laws for all health professions except physicians; (2) licensure for health care institutions; (3) review of the performance of health manpower by a special board; and (4) creation of a medical injury liability compensation system.[19]

The Hershey and Carlson proposals are similar in their repeal of licensure laws for all professions except physicians. Under Carlson's proposal for institutional licensure, however, availibility of capital equipment would be a co-equal criteria for institutional licensure along with statements concerning the qualifications and performance required of personnel to perform different levels of tasks. This proposal is different from the Hershey proposal not only by the requirement for review of capital equipment as a pre-requisite for licensure, but also by a greater emphasis on the qualifications and performance of personnel employed (in contrast to simple job descriptions under the Hershey proposal).

The Health Manpower Board, also an innovation in the Carlson proposal, would be responsible for the review of the competency and performance of the health care labor force. This board would maintain a registry of such information on all personnel to be made available to all institutions, in addition to operating the licensure system for physicians. The medical injury liability compensation system would seek to aid institutions in meeting the anticipated increased financial burden of liability by compensating for injuries claimed by patient not on the basis of fault but on information concerning "expected outcomes" of the treatment process. The operation of this system will be described in fuller detail later. Both the Board and the liability system go beyond Hershey's proposal as indicated in Table 1.

A number of variations have been proposed by several different groups based mainly on Hershey's proposal.[20] An American Hospital Association policy statement in 1971 urged that health care corporations have "specific responsibility for quality and effective delivery of care

TABLE 1

Institutional Licensure
A Comparison of Two Proposals

Hershey - Carlson

Hershey Proposal	Carlson Proposal
Individual Licensure	Individual Licensure
repeal all licensure laws except for independent practitioners (physicians, dentists, optometrists, podiatrists)	repeal of all licensure laws except for physicians (no mention of other independent practitioners)
Institutional Licensure	Institutional Licensure
based on:	based on:
job description (primary) employment requirements review procedure	standards for employment performance of employee availability of capital equipment
Regulatory Agency	Regulatory Agency
expansion of state hospital licensing agency	facilities: "state agency" (unspecified) manpower: "Health Manpower Board" (relationship to facilities unspecified)
Liability Protection	Liability Protection
nothing additional	Medical Injury Liability System -compensation system based not on fault but on "outcomes technology

by all its providers, including those with whom it would contract - physicians, dentists, other health professionals and health care institutions, "though no specific regulatory mechanism was spelled out.[21] The 1971 American Medical Association Council on Health Manpower called for a more limited definition of health institutions (primary hospitals) and for regulation by these institutions of all practitioners except for physicians, dentists, osteopaths and podiatrists.[22] Professional nurses were added to this list of exemptions in 1973. The New Jersey Hospital Association Board of Trustees has called for a reorganization of the current licensure system into six broad areas: medicine, dentistry, nursing, medical technology, medical therapy and institutions. Hospital administrators, nursing home administrators, medical therapy and institutions. Hospital administrators, nursing home administrators, medical record librarians, dietitians and social workers would then be licensed through the institutional part of the system.[23] Finally, HEW is currently supporting two experiments in institutional licensure in Illinois and Pennsylvania following along the general lines of the Hershey proposal.[24] As none of these proposals are very specific (except the HEW experiment which is similar to the Hershey plan), analysis will be concentrated on the proposals made by Hershey and Carlson.

VI. Implications of the Proposals for Institutional Licensure

The implication of institutional licensure will be analyzed along four different dimensions:

Individual liability
Corporate liability and responsibility
The process of litigation for malpractice
The delivery of health care

Emphasis in each area of analysis will be given to the differing legal implications of the two proposals for institutional licensure under consideration.

A. Concepts of Legal Liability

Three fundamental theories of tort liability applicable to medical practitioners and health care institutions alike are (1) lack of informed consent, (2) breach of contract, and (3) malpractice or negligence.[25] Of these three theories, the theory of malpractice or negligence is the most directly applicable to issues involving individual and institutional licensure.

In order to win a civil suit alleging malpractice or negligence in fact, the plaintiff must (a) establish that a relationship existed between a practitioner and himself, (b) prove that some duty existed on the part of the practitioner to the plaintiff, (c) prove that this duty was breached, (d) show that this breach of duty was the proximate cause of injury, and (e) demonstrate that the plaintiff was not contributorily negligent. Of the six usual types of cases brought alleging malpractice, breach of accepted standards of procedure or practice is the most applicable to situations involving licensure and scope of practice.[26]

A suit alleging criminal liability may also be brought if plaintiff can prove that statutory restrictions on the scope of practice of an individual have been breached. Proving criminal liability for such actions will then also result in a presumption of negligence per se, which is a civil action. The significance of this presumption in litigation is that the plaintiff need not prove malpractice as outlined above through expert testimony: criminal conviction alone is sufficient proof of negligence or

malpractice to make the physician and his operative both liable for damages.[27]

B. Individual Liability

The independent medical practitioner is responsible for his actions in the care and treatment of a patient when a relationship between these two is established and when a duty of the physician toward the patient is proven. In essence, this duty and the standard to which the physician will be held responsible is "to possess and to exercise reasonable and ordinary learning, skill and care commonly exercised by like physicians in the same or similar communities."[28]

Neither proposal for institutional licensure will significantly change the responsibility or liability of the independent practitioner in this regard. The Health Manpower Board included in the Carlson proposal, however, will serve to reinforce a system of regional or national standards of care and not just standards of training. Under the Hershey proposal, assigament of responsibility for review of physician performance is left unspecified. If this duty is remanded to existing licensing boards, little improvement in the quality of care may be expected since only one board currently requires periodic re-examination of personnel (American Academy of Family Practitioners) and few boards exert significant disciplinary control over the professionals in their state.

An independent practitioner is also liable, however, for the care and treatment provided by those under his control or direction provided that this superior-subordinate relationship can be proven (the doctrine of respondent superior).[29] A number of factors are considered in the

determination of whether a relationship exists or not:

> The extent of the control the employer may exercise of the details of work:
> Whether or not the person is employed in a distinct business or occupation;
> Whether, in the locality, the type of work is usually performed under the direction of the employer or independently without supervision;
> The skill required in the occupation;
> Who provides the tools, materials and place of work;
> Duration of the employment;
> Method of payment, whether by time or for the job;
> Whether or not the work is part of the employer's regular business.[30]

From the standpoint of the independent practitioner, "Licensure statutes affect malpractice to the extend that in some states violations are admissable as evidence of negligence per se" on the part of the physician.

> If a person is injured in the course of medical treatment and an unlicensed aide or assistant was involved, and if the assistant was performing an act which only a person possessing a certain license is allowed to perform, the law of some states holds that the bare fact that a licensure statute was violated may create a presumption of negligence. The performance of extra-statutory acts by a licensed auxiliary may also lead to a presumption of negligence.[31]

Because of this presumption of negligence <u>per se</u> when using an assistant, the plaintiff is automatically relieved of the burden of proving a breach of a standard of care through expert testimony. The physician, therefore, is at much greater risk of malpractice and damage claims. Carlson argues that such susceptibility to claims of malpractice as well as loss of license inhibit the physician from substituting capable, but otherwise legally unauthorized, persons for his own services.

At issue here is the question of the restrictiveness of the scopes of practice of individual health profession statutes and licensure laws which make experimentation with new patterns of organization in delivery of health

care and utilization of personnel beyond their scope of practice - but within their demonstrated capability - legally hazardous for the physician. By eliminating all forms of individual licensure and restrictive scopes of practice except for independent practitioners, both proposals for institutional licensure give the institution, presumably in cooperation with the physician, greater flexibility in determining exactly which types of personnel will be allowed legally to perform which tasks. It is important to point out that after this determination is made, independent practitioners will still be liable to those standards for utilization established in job descriptions and requirements of employment under the conditions noted above. All that has been changed by institutional licensure is the ability of the institution to assign different functions to different categories of personnel based on skill and experience and not just on broad qualifications for a general occupation or field. Most of the detailed restrictions on use of personnel will have been eliminated.

Both proposals, however, differ in the means and standards by which individuals will be judged. The Hershey proposal places principle emphasis on the job description as setting the parameters for practice and the minimum standards for employment. The Carlson proposal places greater emphasis on the qualifications, skill and experience which an individual brings to an institution and which he exercises in the course of his employment as determinent of the licensure of an institution. Because of the variability possible in the standards set by each institution, both proposals potentially pose unique problems for the legal determination of what constitutes the "possession and exercise of ordinary learning, skill and care commonly exercised by like persons in the same or similar communities."

The meaning of "like" under these circumstances may be blurred considerably. By its emphasis on the statement of a job description, however, the Hershey proposal would appear to be susceptible to greater standardization and uniformity than the more loosely structured proposal to base employment and institutional licensure on specific skills and performance as suggested by Carlson. Thus, the Hershey proposal may provide the plaintiff with a better opportunity to prove a standard of care through expert testimony than the Carlson proposal. From the standpoint of potential litigation, the Carlson proposal favors the provider while the Hershey proposal favors the consumer.

Both proposals obviously have implications for the legal liability of the dependent practitioners as well. Under the current system of licensure, an individual is restricted to those acts defined within his scope of practice and is then held to the standard of care of "like persons in similar communities," etc. Any extrastatutory acts of the licensed individual makes him criminally liable as well as liable for civil damages for his acts under the doctrine of negligence per se.[32] If the act performed is a medical act for which the person has no legal authorization, the individual will be held to the same standards as that of a physician rather than an individual with similar training as himself. The unlicensed or legally unauthorized person under the current system of licensure, therefore, is a greater risk for both criminal and civil suits because of the standard of care employed as well as the automatic presumption of negligence.

By eliminating the rigid definitions of scopes of practice, both the Hershey and the Carlson proposals introduce new standards for practice

based on skill and training rather than simply "general" qualifications. The issue to be determined in future malpractice litigation under a system of institutional licensure will be whether a dependent practitioner, in fact, had the requisite skill for his position as well as whether the skills required were commensurate with the demands of the job.

In regard to this last point, considerable question must be raised as to whether or not institutions will be allowed to "downgrade" job qualifications to match the characteristics of the local supply of labor. The possibility of having variable standards to meet each institution's own needs has been offered as one of the major advantages of institutional licensure. If local variations are not permitted, as may well be the case given the trend in the courts in the application of regional and national standards in malpractice cases, then the probable effect of the Hershey proposal (with its greater propensity for uniformity and standardization of practices) will be to substitute job descriptions for practice definitions as the basis for determination of standards in malpractice litigation. Because the Carlson proposal is not as amenable to standardization of scopes of practice as the Hershey proposal, emphasizing as it does performance rather than job characteristics, the assistant may have an easier time defending himself through use of local references and proof of competency. In short, the dependent practitioner may find himself at similar risk for civil and criminal liability under the Hershey proposal as under the existing system of restrictive individual licensure, but at considerably less risk for the same functions under the Carlson proposal.

C. Corporate Liability

Determination of institutional liability may rest on two bases: vicarious liability of the institution under the doctrine of respondent superior and corporate negligence based on the duties owed by the institution to others.[33]

1. Vicarious Liability

At issue under the theory of vicarious liability is the relationship of the employee to the institution. "In theory, vicarious liability is based upon the right of the employee to control the means and methods of the employee's performance of his work."[34] The hospital has always been liable for the excerise of due care in the selection of its employees. Beyond this, however, determination of the susceptibility of an institution to liability for the actions of its employees historically was based primarily on the nature of the organization, i.e. whether it was private for-profit, private voluntary or public, and the nature of the act in question. Doctrines of immunity, which formerly protected both public and private non-private institutions alike from liability for their employees, have gradually been overthrown.[35] Only recently, however, has the traditional distinction between the employees' functions in the hospital qua institution and his functions as part of the medical treatment process been merged into a single theory of corporate liability.

With regard to the "independent practitioner," receipt of a salary or even a contractual arrangement to provide services, is sufficient grounds for vicarious liability on the part of the hospital for the physician's actions.[36] The doctrine of apparent or ostensible agency, which holds that an institution is liable for the actions of an individual

appearing to be an employee even though not in fact an employee, is also being applied with greater frequency. Traditionally, the hospital provided staff such as nurses and aides to work with the physician, and then claimed immunity from liability for the actions of these individuals under the doctrine of "the borrowed servant."[37] Ultimate responsibility for these employees' actions, however, is now reverting back to the hospital both on the basis of the hospital's newly defined responsibility to the patient for the quality of care (Darling Case) and on the basis of the well recognized doctrine of respondent superior. In short, the hospital is no longer looked upon merely as the "doctor's workshop" but is now considered legally to be a provider of services in concert with all of its employees.[38]

This change in the vicarious liability of the hospital is in keeping with the move towards centralization of the delivery of health care in institutions such as hospitals, ambulatory care centers and group practice clinics. Institutional licensure, which recognized de jure what the courts are recognizing de facto as the new bounds of institutional liability, fits well into this pattern of institutionalization of care. By vesting explicit responsibility for the quality of the personnel and the tasks which they perform in the institution, neither the Hershey nor the Carlson proposals will significantly change the newly redefined nature of a hospital's vicarious liability. In fact, by ceding greater control over these individuals to the institution, thus breaking the hold which professional organizations have had on groups of employees, both proposals for institutional licensure will increase the ability of the institution to improve the quality of its care to match the legal liability which the institution now carries. The Illinois experiment in institutional licensure bears out the optimism of these statements.[39]

At the same time, it is unlikely that either proposal will significantly increase the liability of smaller, less formal institutions, given the current trends in court decisions regarding institutional responsibility for quality of care.

The one important advantage which the Carlson proposal holds over the Hershey proposal is the plan to establish a system for compensation of liability claims. Carlson argues that the basis for indemnification should be on proof of the breach of standards of "expected outcomes" rather than on the more process-oriented standards as scope of practice or procedure. While the practicality of such a scheme, even with improved data handling and computer technology, is at best problematical, the concept of the pooling of financial risks of health care institutions is consistent with the realization of increased institutional liability for care. Obviously the risk of financial loss operates as an incentive for the institution to maintain a high level of care and the pool should not protect an institution from this important incentive. The pool should, however, help the institution to meet some of its financial burden resulting from liability claims in order to assume that institutions don't succumb to the temptation of bankrupting their care for the settlement of claims.[40]

2. Corporate Liability

Historically, the principle duties owed by a hospital to a patient were "a duty to exercise reasonable care in the employment of hospital paid employees, a duty to exercise reasonable care in the maintenance of buildings and grounds,...and a duty regarding the maintenance and selection of hospital equipment."[41] The case of Darling vs. Charleston Community Hospital in 1966, however, "finally settled that the administration of a hospital is required

to review the qualifications of the medical staff systematically, that consultation should be required of attending physicians, and that legal standards of care may encompass standards promulgated by organizations like the Joint Commission on the Accreditation of Hospitals, the Supreme Court of Illinois recognized the clear responsibility of the hospital not only for its facilities but also for the quality of the care provided within its walls.

Both proposals for institutional licensure recognize this issue by making the institution directly accountable through the process of licensure for the quality of care it provides. The Carlson proposal, however, goes much further in recognizing the extent of a hospital's corporate liability by specifying that licensure of an institution should be based both on the quality of its employees and on the nature of its capital equipment. The Hershey proposal, which only goes as far as validating an institution on the basis of how it proposes to use various categories of personnel, represents a more conservative approach to the establishment of standards for licensure. The potential danger in establishing minimum requirements for equipment as well as personnel is the exclusion of many institutions that may be labor rather than capital intensive, although equivalent in terms of quality with capital intensive institutions. A principal objective of both institutional licensure proposals is to increase the flexibility of institutions in the utilization of their resources. The establishment of too many requirements may inhibit innovation and prevent efficient utilization of given resources, thus decreasing rather than increasing flexibility. Whether the Carlson proposal poses a real threat of over-regulation or not will depend on the degree of specification of requirements

for equipment as well as standards of operation made by the regulating state agency.

While little has been said so far about the role of an institution's Board of Trustees or its administration, it is clear from the facts presented above that Trustees will have to have much more information regarding the operation of their institution under systems of institutional licensure than ever before. Responsibility of the Board has expanded beyond simple concern for care in the selection and appointment of staff to a concern, involvement and joint responsibility with the medical staff for the actual quality of the care provided. The requirements of time and knowledge on the part of the Trustee thus will also increase, making the job of finding persons who are capable and willing to volunteer their time more difficult. The importance of an institution's administration is equally increased as responsibility for providing adequate information to the Trustees as well as responsibility for the proper management of the facilities of an institution growth. Needless to say, implementation of either proposal for institutional licensure will necessitate greater involvement of legal staff in institutional affairs to assure proper exercise of clearly defined duties and responsibilities for health care delivery.

D. The Process of Malpractice Litigation

It is difficult and hazardous to judge what the ultimate impact of any system of institutional licensure will be on malpractice litigation because of the fluidity of this field of law and the current uncertainty concerning the extent of criminal and civil liability to result from such precedents as the Barber and Warren cases.[43] If these cases, especially

the Barber case, represent a trend towards holding individual practitioners strictly accountable to their legally defined scopes of practice, institutional licensure will have a significant impact in reducing the possibility of criminal and civil suits by eliminating many of the perhaps artificial and definitely outdated barriers to more efficient use of personnel. If these cases represent only abhorrent decisions from the norm of allowing custom and usuage to dictate proper standards of care, then the impact of institutional licensure on reducing criminal prosecution and resultant claims of negligence per se in civil actions will be much less.

As suggested above, the central issue in claims of malpractice and the coincidental utilization of new types of personnel is the clarity and specificity of the regulations governing who is legally allowed to perform procedures which may have resulted in injury to the claimant. These regulations not only would fix responsibility for the act in question, but would also determine the specific referrent standard to be used in judging whether a breach of proper care occurred or not. For instance, if an act performed by an individual was specifically reserved for a person with greater training, then the individual will be held to standards of that more highly trained person rather than to an individual with training similar to that of his own. The two proposals for institutional licensure may have different impacts on the process of malpractice litigation, depending on how explicit the standards generated by the state regulatory agency under each proposal are in authorizing the separation of functions for different types of personnel.

By basing standards for institutional licensure on explicitly stated job descriptions which outline the qualifications of an individual for a

position as well as his duties, the Hershey proposal would appear to be susceptible to the same type of rigid definition of functions by type of personnel as the current system of individual licensure with its restricted scopes of practice. If this standardization were to occur, the flexibility of institutions to specify job descriptions which meet their own requirements and resources would be limited, thus defeating a major objective of institutional licensure. Such standardization may indeed result as state regulatory agencies will probably rely on uniform models of job descriptions in the interest of administrative expediency and efficiency. Hershey's proposal, therefore, threatens to substitute one form of standard definition of division of labor - individual licensure and scope of practice - for another - job descriptions.

Carlson's proposal puts much greater emphasis on the assessment of the skills and training required of individuals for their employment in an institution as well as their ongoing performance. To this extent, Carlson's proposal avoids the hazard of establishing fixed roles and functions for various categories of personnel and is much more in keeping with the trend towards dependence on usage and custom for definition of standards of practice.

While it has been argued here that regulation and statutes may be used against health care providers, these same statutes may also provide a degree of protection for the practitioner to the extent that conformance to the prescribed laws makes challenge of a standard or practice more difficult for the plaintiff. In the latter case, the plaintiff is left only to prove through expert testimony that the act in question was negligent <u>in fact</u>. Proof of this fact is much more difficult than proving breach of a legal statute per se. From a public policy perspective, therefore,

a clear tradeoff exists between the desirability of protecting the consumer's ability to claim and to prove malpractice when it occurs and the desirability of maintaining as much flexibility in the utilization of personnel as possible to cut costs and to increase the overall quality of care.[44] At this point, a subjective opinion may be offered that greater freedom in use of personnel may ultimately lead to a higher standard and quality of care which, after all, is the principal objective of any system of licensure. The plaintiff still has resort to litigation based on claims of malpractice in fact.

A final possible implication of institutional licensure that may be mentioned relates to the question of the volume of litigation to be expected as a result of a change to a system of institutional licensure. It is conceivable that because an institution is "impersonal" and may be perceived to have greater resources by virtue of its size, consumers may be more willing to institute actions claiming malpractice, particularly if the individual feels that he is receiving "clinic-type" care. While such an hypothesis is merely conjecture, proof of such a change in behavior would increase the importance of Carlson's proposal to establish a medical liability compensation system to assist institutions in meeting this financial threat. Further research on this problem will have to be done before more definitive conclusions can be reached concerning the probable impacts of a change to a system of institutional licensure on the volume of malpractice litigation.

E. The Delivery of Health Care

The principal focus of this analysis has been on the legal implications of two proposals for institutional licensure. Little emphasis has

been given to the potential impact of these systems for the delivery of health care not because they are unimportant, but because a more full discussion of these issues would exceed the scope of this analysis. Nevertheless, a number of the benefits expected to result from either system of institutional licensure may be summarized briefly.

Supply of Health Manpower. Emphasis on skill and proficiency and de-emphasis on formal education are intended to reduce many of the entry barriers now posed by restrictive licensure laws and thereby to increase the potential size of the work force. Advancement based on skill and proficiency will hopefully result in an increase in vertical career mobility and improvement in the retention of personnel which will also help to expand the potential pool of available manpower.

Distribution. Elimination of the many conflicting statutory requirements for licensure extant in the U.S. today will improve possibilities for increased geographic mobility of personnel, assuming that states do not develop new sets of differing requirements based on job descriptions, personnel qualification statements, etc.

Quality. By eliminating the restrictive provisions of existing licensure laws relating to use of personnel, institutions will be allowed much greater flexibility in the deployment of personnel and will be allowed greater freedom to experiment with new and potentially better patterns of health care delivery. The quality of services provided per unit of existing manpower will, therefore, be increased.

Cost. With better utilization and a reduction in the requirements for high cost, time-consuming education, the costs of health care should be held down under institutional licensure. Increasing the supply of

health manpower may also increase the availability as well as reduce the cost of care.

Accountability. The stranglehold which individual health care professions have over the practice of their own profession will be weakened significantly through the elimination of licensing boards. Responsibility for the quality and cost of care will be shifted to the health care institutions which not only provide the care but which also now share in the legal responsibility for that care with other providers.

VII. Conclusion

As outlined in the introductory sections, the principal public objective for any system of licensure should be the assurance of a certain level of quality of product or output. The system of individual licensure for health manpower has failed to achieve this goal not only because the statutes specify only minimal qualifications for practice, emphasizing inputs rather than outputs, but also because the system does not provide for adequate, ongoing assessment of quality over time.[45] Licensure remains a one-time check on inputs only.

Using this quality objective as a standard against which to compare the two proposals for institutional licensure, the Hershey proposal emerges as the weakest conceptually. Hershey's emphasis on job descriptions really is only a restatement of a concern for i put rather than output measurement of quality. The checks on ongoing quality suggested by Hershey relate more to education than to performance. Carlson's proposal, on the other hand, goes much further towards the development of an ongoing system to measure the quality of the output of health

manpower and not just the quality of inputs with its emphasis on a health manpower review board to monitor and catalog manpower performance. Assignment of institutional responsbility for both personnel and capital equipment is spelled out much more precisely under the Carlson proposal than under the Hershey proposal. As indicated in the analysis, however, this specification may prove too restrictive, a least for the time being, until better measurement of the tradeoffs between labor and capital intensive institutions with regard to quality can be made.

The Hershey proposal, which emphasized job descriptions as the basic unit of institutional analysis, may not result in the desired improvement in vertical career mobility or horizontal job mobility if great variation develops among institutional definitions of job duties and qualifications. An individual working at a job in one hospital, for instance, may not be qualified, or may be over-qualified, for that same position in a different institution. If greater uniformity in job descriptions occurs as a result of the necessity for administrative expediency on the part of the state regulatory agency, many of the restrictive features of individual licensure laws may simply be rewritten as codified job descriptions, with little change in the potential criminal liability of either independent and dependent practitioners. Carlson's emphasis on skill and performance of an individual, however, may result in much greater vertical as well as horizontal mobility as an individual will be permitted to seek that job offering the greatest return on his qualifications.

Both proposals are open to the same criticism that existing health care institutions may not have adequate staff capability to make decisions on who to hire or what to define as a job. This criticism is particularly valid for the Carlson proposal which emphasized the measurement of individual

performance as the standard for evaluation which is a very difficult and highly specialized problem. Under the existing system, professional leaders make most decisions on standards and requirements for practice as the ones most knowledgable of their own work and training. Undoubtedly under a system of institutional licensure, hospital administrators will eventually develop the skills necessary for such decisions. In the interim or until existing skills are diffused more equally throughout the system, however, the medical staffs of hospitals will either reassert their control over all other professions or the quality of care provided by institutions will be endangered. One of the inevitable consequences of the implementation of institutional licensure will be an increase in the professionalization of hospital administrators requiring perhaps that these individuals be certified in a comparable fashion to that of the medical staff of an institution to assure quality administration.

A trend which both proposals overlook is the increasing unionization of various employee groups in hospitals. Unionization implies significant control over the work process by labor which may severely limit the ability of an administration to take full advantage of the flexibility in work assignments offered by a system of institutional licensure. To date, proponents of institutional licensure have not addressed this problem sufficiently to propose any solutions or modifications to their original proposals.

Mention has not yet been made of the opposition which can be expected to any system of institutional licensure by most of the established professions. The professional nursing associations have been the most vocal in their opposition to all forms of institutional licensure whether the associations

are left with control over their own profession or not.[46] Realistically, as Tancredi and Woods point out, the Hershey proposal for institutional licensure may be more of a means than an end in itself, the end being a system of quality control where emphasis is placed on output rather than on input measures.[47] While Carlson's proposal points toward a system that will provide greater guarantees of quality control, better techniques of measurement and standardization of health care outcomes and health manpower performance must be developed before this system can become a reality. Only then will licensure as a system of quality control work effectively to protect the public's health, safety and well-being as was the original purpose for a system of licensure.

FOOTNOTES

[1]D.H.E.W., Licensure and Related Health Personnel Credentialing (Washington: U.S.G.P.O., June, 1971) p.7.

[2]Ibid., p.7.

[3]Ibid., p.7.

[4]L. Friedman, "Freedom of Contract and Occupational Licensing 1890-1910: A Legal and Social Study," California Law Review, 53:487,493. Cited in Laurence Tancredi and John Woods, "The Social Control of Medical Practice," Milbank Memorial Fund Quarterly, 50:99-125 (January 1972), p.100.

[5]Ruth Roemer, "Licensing and Regulation of Medical Care and Medically-Related Practitioners in Health Service Teams," Medical Care, IX, No.1:42-54 (January-February 1971), p.44.

[6]T. Gale Moore, "The Purpose of Licensing," Journal of Law and Economics, IV (October 1961), pp.93-117.

George T. Stigler, "The Economics of Information," Journal of Political Economy, (June 1961).

H.E. Frech, "Occuaptional Licensure and Health Care: An Analytical Review," Draft paper (1972), pp.47.

[7]Frech, "Occupational Licensure," pp.3-4.

[8]Frech, "Occupational Licensure," pp.3-4.

[9]Frech, "Occupational Licensure," pp.11-35.

[10]D.H.E.W., State Licensure of Health Occupations, No.1758 (Washington: Public Health Service, National Center for Health Statistics, October 1967), pp.2-3.

[11]Ibid., p.3.
Voluntary licensing represents situations where "only persons holding a license are authorized to use a particular title or official designation: unlicensed persons are not prohibited from working in this field but they may not use the protected title." Compulsory licensure is where "only persons holding a license are permitted to practice the occupation, and unlicensed persons are prohibited from working in the field."

The Federal Tort Claims Act of 1945 now regulates claims for damages of less than $1,000 brought against Federal Institutions without Congressional interposition, while constitutional provisions, state or municipal acts regulate claims against state, county and municipal institutions.

Private, non-profit community hospitals traditionally were immune from liability for the actions of their servants under a variety of doctrines: the trust fund theory, exemption by implied waiver, the rule of respondent superior as grounds for exemption, public policy theory, and the theory of the independent contractor. Precedent is being established, however, for greater liability of eleemosynary institutions for claims of malpractice and negligence. Proprietary hospitals have always been and remain responsibile for the actions of their employees.

[36]Southwick, "The Hospital," p.19.

[37]The doctrine of the "borrowed servant" holds that an individual temporarily directing the actions of another, as a physician to a nurse, is vicariously responsible for those actions as the original employer, in this case the hospital, has no direct control over the nurse. See Southwick, "The Hospital," p.21.

[38]Southwick, "The Law," pp.92-93.

[39]Personal conversation with Dr. Peterson, Director of the Illinois experiment in institutional licensure, at a seminar held on the issue of institutional licensure as part of the Michigan Nursing Association's Annual Conference in Detroit, October 19, 1973.

[40]A system of payments for institutions could be arranged, for instance, whereby the size of the contribution is based on such factors as size, complexity, etc., but also on the basis of the number and size of claims made. In this way, an institution with a high number of claims successfully litigated by the plaintiff would "pay" the price which would reinforce the incentive to improve care or simply to go out of business. The amount paid, however, would be proportionately less than the amount of the claim settlement.

[41]Southwick, "The Hospital," p.24.

[42]Hayt et al., Law, p. 325
Darling v. Charleston Community Hospital, 211 N.E. 2d. 253 (Ill.).

[43]Barber v. Reinking, 411 p.2d 861 (1966).
State Board of Medical Examiners v. Warren Hospital, 246 A. 2d 78 (1968).

[12]Rick J. Carlson, "Health Manpower Licensing and Emerging Institutional Responsibility for the Quality of Care," Law and Contemporary Problems, 35, No.4 (Autumn, 1970), pp.849-879.

[13]Ibid., p.862.

[14]Ibid., p.860

[15]The work done by CPHA with their PAS and MAP systems is an excellent example of the increased ability to provide "process" measurements which then can potentially be linked to morbidity, mortality and demographic data for purposes of analysis of "outcome" or "expected outcome".

[16]Intermediate health care personnel are taken here to mean not only physician assistant and physician extender types of personnel, but also the newly emerging specialties within nursing practice. Nurses view their role vis-a-vis the physician more in terms of "collaboration" than simply assistance to or substitution for the physician. Rather than begin a lengthy description of the implications of each type of personnel for the delivery of health care, this analysis will assume both types to be equally important in their respective roles and will focus on the means by which these persons may be used more effectively legally.

[17]Harris S. Cohen,"Professional Licensure, Occuaptional Behavior and the Public Interest," Milbank Memorial Fund Quarterly, Health and Society 51 (Winter), 73-88.

[18]Nathan Hershey, "An Alternative to Mandatory Licensure of Health Professionals," Hospital Progress (March 1969), pp.71-74.

Nathan Hershey and Walter S. Wheeler, Health Personnel Regulation in the Public Interest (The California Hospital Association,1973), pp.3-23.

[19]Carlson, "Health Manpower Licensing," pp.875-879.

[20]Betty C. Agree, "The Threat of Institutional Licensure," American Journal of Nursing (October 1973), pp.1758-1763.

[21]American Hospital Association, "Statement on Licensure of Health Care Professionals," Hospitals, 45:82ff. (March 1971).

[22]Council on Health Manpower, American Medical Association, Licensure of Health Occupations (Chicago: The Association, 1970).

[23]Agree, "The Threat," p.1759.

[24]Agree, "The Threat," p.1759.

[25] Arthur Southwick, "Liability of Health Care Professionals," Lecuture, Ann Arbor, Michigan (October 31, 1973).

[26] The remaining five typical cases of malpractice in fact are:
superficial or hasty diagnosis or treatment;
failure to consult prior physicians or medical records;
failure to use proper instruments;
failure to consult with specialists, etc.;
abandonment.

[27] Carlson, "Health Manpower Licensing," p.852.

[28] Southwick, "Liability," favalora v. Aetna Cas. & Surety Co., 144 So. 2d 544 (La.App.) (1962).

[29] Respondent superior' is a principle of law whereby the master is held answerable for the acts of his agent or servant. It is founded on the duty which rests on every man, in the management of his own affairs, whether by himself or by his agents or servants, so to conduct them as not to injure another; if he is careless, and another is thereby injured, he will be responsible for the damage." Emanual Hayt, Lillian Hayt and August Groeschel, "Liability of Voluntary Hospitals to Patients," in Law of Hospital, Physician and Patient (3rd ed., New York: Physician's Record Company, 1972), p.289.

[30] Hayt et al., Law p. 637.

[31] Carlson, "Health Manpower Licensing," p. 852.
In support of this statement, Carlson cites the following:
Annot. 44 A.L.R. 1418 (1926); Annot. 57 A.L.R. 978 (1928).
Also Willet V. Rowekamp, 1340 O.St. 285, 16N.E. 2d 457 (1938);
Janssen v. Mulder, 232 Mich. 183, 205N.W. 159 (1925);
Joly v. Mellor, 163 Wash. 48, 299 P.660 (1931);
Monohan v. Devinney, 131 Misc. 248, 225 N.Y.S. 601 (sus. Ct., 1927);
Barber v. Reinking, 68 Wash. 2d. 139, 411 P. 2d 861 (1966).

[32] Carlson, "Health Manpower Licensing," p.852.

[33] Arthus Southwick, "The Law of Hospital Liability," Legal Medicine Annual (1970), pp.91-115.

[34] Arthur Southwick, "The Hospital as an Institution," Prepublication draft (September, 1973), p.18.

[35] Public Institutions formerly were exempt from liability under the doctrine that "the king can do no wrong."

> The modern tendency is to abolish the fiction that the sovereign can do no wrong. However, unless there is an express statute to that effect, the state is not liable for nonperformance or improper performance of its governmental powers (as opposed to its medical treatment activities).
> (Hayt, Law, p.309)

[44]It may be, for instance, that an experienced surgical assistant who performs the same set of operations day after day possesses greater skill in the exercise of these procedures than a physician who uses these skills only at irregular intervals.

[45]Southwick, "The Law," p. 101.

[46]Michigan Nursing Association, "Proposed Statement and Rationale in Opposition to Institutional Licensure," 1973 MNA Convention, Detroit Michigan, October 19, 1973.

[47]Tancredi and Woods, "The Social Control," p. 119.